STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING _____ B. WING _____	C 01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG, LLC THE	1350 N TODD DR SCOTTSBURG, IN 47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for a Recertification and State Licensure Survey. This visit included the investigation of complaint IN00083798. Complaint IN00083798- Unsubstantiated due to lack of evidence. Survey date(s): January 23, 24, 25, 26, 27, 2011 Facility number: 000478 Provider number: 155494 AIM number: 100290430 Survey Team: Donna Groan, RN, TC Avona Connell, RN TC 2/9/11 SW Avona Connell, RN Gloria Reisert, MSW Census bed type: SNF/NF: 83 Total: 83 Census payor Type: Medicare: 08 Medicaid: 71 Other: 04 Total: 83 Sample: 17 Supplemental sample: 12 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on January 31, 2011, by Bev Faulkner, RN	F 000	RECEIVED FEB 17 2011 LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH **Preparation and execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by the facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.**	
F 151	483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS	F 151	F 151 **Right to Exercise Rights – Fear of Reprisal** It is the intent of this facility to provide an environment where residents who voice concerns do not feel intimidated, or fear reprisal.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Lisa Davis by William Schelter | Administrator | 2/17/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING _____ B. WING _____	C 01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG, LLC THE	1350 N TODD DR SCOTTSBURG, IN 47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 151 SS=D	Continued From page 1 - FREE OF REPRISAL The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a resident who voiced concerns did not feel intimidated or feared reprisal for speaking out for 1 of 8 residents reviewed for resident rights in a supplemental sample of 12. (Resident #47) Findings include: The clinical record for Resident #47 was reviewed on 1/25/11 at 2:07 p.m. The resident had diagnoses of Dementia with Behaviors and Schizophrenia. The resident currently resides on a secured locked unit. The resident was identified by the Activity Director, as alert and oriented, and was in attendance at the Group Meeting held on 1/26/11. After the Group Meeting on 1/26/11 at 10:30 a.m., the Ombudsman provided residents with her information including telephone numbers and the phone number for the Indiana State Department of Health Long Term Care Division. On 1/25/11 at 3:22 p.m., in interview with the Social Worker, she indicated the resident was an elopement risk. Documentation was lacking in	F 151	1. Action Taken: • Staff discussed concerns with Resident #47. Assured her she could voice conerns without fear of reprisal. • DON discussed concerns with Guardian, Guardian completely satisfied with process. • Facility reported and investigated allegation of abuse against survey team. 2. Others Identified: • Social Service Director conducted interviews with facility residents to determine if anyone felt this way. No others indentified. 3. Systems in Place: • Inservice all staff and residents on Residents Rights 4. How Monitored: • Social Service Director to review during monthly Resident Council Meeting and report negative findings to facility Administrator immediatley.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING _____ B. WING _____	C 01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG, LLC THE	1350 N TODD DR SCOTTSBURG, IN 47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 151	Continued From page 2 the clinical record the resident had been exit seeking and or attempted to elope. At this time, she was asked if Resident #47 could be observed off the secured unit and near the main nurse station. She indicated she would look into the resident request. On 1/26/11 at 2:15 p.m., Resident #47 indicated "I just want to sit out at the nurse's station. It's a joy you're here." On 1/27/11 at 9 a.m., Resident #47 was observed in her room. At this time, she motioned for the surveyor to enter her room. She was smiling and expressed thankfulness for assisting her for more time off of the locked unit. The resident indicated she was afraid of retaliation from the staff. She was assured staff could not retaliate and was reminded she had the Ombudsman's telephone number as well as the Indiana State Department of Health phone number on a form given to her at the Group Meeting. On 1/27/11 at 10:10 a.m., the Administrator and Director of Nursing entered the conference room. At this time, they indicated they had made rounds on the Secured Unit. Resident #47 was asked if she was all right and she indicated she didn't have to talk to them and the resident was upset. On 1/27/11 at 11:05 a.m., the Social Worker brought Resident #47 to the conference room. She was taken to the Director of Nursing Office where the Administrator was before seeing the surveyors. The resident asked the Social Worker why she was taken to their office. There was no response.	F 151	• SSD to report findings to Quality Assurance Committee and Medical Director on a quartely basis. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is February 26, 2011.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING _____ B. WING _____	C 01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG, LLC THE	1350 N TODD DR SCOTTSBURG, IN 47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 151	Continued From page 3 The Social Worker was asked to stay with the resident while she spoke. She was extremely anxious and trembling. She began " I'm upset. "I told you this would happen. "The [named] Administrator and [named] Director of Nursing came to my room and closed the door. I told them not to close the door. They wanted to know if one of the surveyors told me to shut up or slapped me on the hand. I told them they were trying to get the surveyors in trouble. I told them I didn't want to talk to them no more and to get my nurse. Now they are intimidating me. I told you this would happen. They are wanting to know what we talked about yesterday." The resident was assured she did not have to tell them what we discussed as it was private. Review of the "Your Rights as a Nursing Home Resident" provided on 1/23/11 at 3 p.m., included, but was not limited to: "Quality of Life in the Nursing Home You have a right to: Voice complaints or grievances without fear of retaliation. The nursing home must give you information about how to file a complaint with the facility, the Ombudsman, and with the Department of Health, Long-Term Care Division..." 3.1-3(a) 3.1-3(a)(2)(D)	F 151		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment	F 225	F 225 **Investigate/Report Allegations/Individuals** It is the intent of this facility to report and investigate all allegations of abuse.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING _____ B. WING _____	C 01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG, LLC THE	1350 N TODD DR SCOTTSBURG, IN 47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 4 of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure an allegation of abuse was reported to other officials in accordance with State law and thoroughly investigated for 1 of 2 residents in a supplemental sample of 12 reporting an allegation of mistreatment.	F 225	1. Actions Taken: • Administrator witnessed interaction between COTA and Resident #25. Resident immediatley stated to Administrator "I said that so I wouldn't have to go to therapy". • Allegation reported ad investigation completed-no substantiated findings • Psych services were notified due to residents history of manipulative behaviors 2. Others Identified: • Social Service Director interviewed other residents receiving services from the COTA. No concerns noted. 3. Systems in Place: • Staff inserviced on Abuse Policy for investigation and reporting of all allegations of abuse, and including how it relates to Chronically Mentally Ill residents' and their behavioral plan of care.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING _____ B. WING _____	C 01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG, LLC THE	1350 N TODD DR SCOTTSBURG, IN 47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 5 (Resident #25) Findings include: The clinical record for Resident #25, was reviewed on 1/25/11 at 10:15 a.m. The resident diagnoses included, but were not limited to: aortic stenosis, seizure disorder, chronic paranoid schizophrenia, and mild mental retardation. Nurses notes on the following dates indicated "Res. A&O X 3. (Alert and oriented times three) November 19, 2010, at 9:40 p.m.. November 20, 2010, at 9:05 p.m. December 2, 2010, at 11:00 p.m. December 7, at 4:30 p.m. December 8, at 1:00 a.m. December 9, at 01:24 a.m. January 6, 2011 at 10:35 p.m. January 7, 2011 at 02:21 a.m. January 11, 2011 at 2:00 p.m. Jan. 12, 2011 at 4:15 p.m. The Physical Exam, dated 12/4/10 and signed by the resident's physician, indicated under Neuro: the resident was A&Ox3. On 01/24/11 at 9:10 a.m., the resident was overheard saying to the Administrator "I am not going to therapy anymore as that lady hit me." On 01/24/11 at 9:20 a.m., when the Administrator was asked as to who hit the resident, she provided a handwritten statement, dated 1/21/11, and signed by (name of Certified Occupational Therapist Assistant(COTA). The letter indicated: "I was in (name of resident) room and asked her to come down to therapy. I	F 225	4. How Monitored: • All allegations of abuse will be monitored/audited by the DON/Designee. • All audits will be reviewed by the ADM/Designee in the morning QA meeting when/if allegations occur. • All Abuse Allegations and reports made to ISDH will be reviewed by the Medical Director and Quality Assurance Committee on a quarterly basis. 5. This plan of correction constitutes our credible allegation of complaince with all regulatory requirements. Our date of compliance is February 26, 2011.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING _____ B. WING _____	C 01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG, LLC THE	1350 N TODD DR SCOTTSBURG, IN 47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 6 told her I was going to get another resident to join us and that I would meet her in the gym (two times). before going to get other resident. Resident must not have heard me as when I was bringing other resident she was going back toward her room (leaving gym) by the (name of unit resident resides on) nurses station. I walked over to ask her to come back down and since I was approaching her from behind and on her side (I did not want to startle her) I touched her hand (and maybe her arm) I tried asking her to come down and explain I went to get other resident. Resident (name of resident) started yelling that I hit her not to hit her. Resident stated she was already down at gym and I wasn't there and she didn't want to come back down. I went back down to the gym with the other resident." On 01/24/11 at 12 p.m., when the Administrator was asked if she reported the allegation to the State, she replied "no" as I was there and the COTA did not hit her. She was asked, if she investigated the allegation and again she replied "no". The Administrator indicated she had not documented her observation of the event. She later provided a typed letter on 1/24/11, 12:20 p.m., indicating she observed the event, examined the resident's hand and did not see a mark. She indicated the resident stated she was hit so she wouldn't have to go to therapy again. She indicated the resident "stated she didn't want to go to therapy and we couldn't make her." The letter indicated she spoke with (name of COTA), and she stated she placed her hand on (name of resident) hand so she wouldn't startle her. She denied hitting her and said she did not think she touched her with enough force to feel	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING _____ B. WING _____	C 01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG, LLC THE	1350 N TODD DR SCOTTSBURG, IN 47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 7 like a hit. On 01/24/11, the Social Worker made an addition to the resident's care plan "making false accusations in order to obtain attention/manipulation --may refuse/resident therapy/ADL etc." Goal: "No further episodes of making false accusations thru next review." "Will co-op with care & therapy, ADL (activities daily living) etc 5X week by next review." On 01/26/11 at 10:25 a.m., the resident in interview indicated the COTA hit her hand and demonstrated a forceful hit to the top of her left hand. She indicated no administrative staff was present to witness event. 3.1-28(c) 3.1-28(d) 3.1-28(e)	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, and interview the facility failed to implement their abuse policy for thorough investigation and reporting to the state agency for 1 of 2 resident who voiced an allegation of abuse in a supplemental sample of 12. (Resident #25)	F 226	F226 **Develop/Implemet Abuse/Neglect, Etc Policies** It is the intent of this facility to implement the abuse policy for thorough investigation and reporting of all allegations of abuse. 1. Actions Taken: • Administrator witnessed interaction between COTA and Resident #25. Resident immediatley stated to Administrator "I said that so I wouldn't have to go to therapy".	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING _____ B. WING _____	C 01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG, LLC THE	1350 N TODD DR SCOTTSBURG, IN 47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 8 Findings include: On 01/24/11 at 9:10 a.m., the resident was overheard saying to the Administrator "I am not going to therapy anymore as that lady hit me." When the Administrator was asked as to "Who hit the resident" she provided a handwritten statement, dated 1/21/11, and signed by (name of Certified Occupational Therapist Assistant(COTA). The statement included, but was not limited to: "I was in the resident room asked her to come down to therapy I told her I was going to get another resident to join us...I walked over to her and approached her from behind (I did not want to startle her) I touched her hand (and maybe her arm) I tried asking her to come down...she started yelling I hit her and not to hit her...." The resident reported on 01/21/11 that the COTA hit her. The facility failed to follow the facility policy related to investigation of abuse. The facility's Abuse Investigation Policy was reviewed on 01/24/11 at 12:00 p.m. Page 17.6 indicated the following: "Policy" It is the policy of the facility that reports of verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, and misappropriation of their property (collectively), sometimes referred to as events") are promptly and thoroughly investigated. Procedure: 1. When an event or suspected event as defined above is reported, the Administrator/Designee or an Abuse Prevention Coordinator will investigate	F 226	• Investigation completed-no substantiated findings • Psych services were notified due to residents history of manipulative behaviors 2. Others Identified: • Social Service Director interviewed other residents. No concerns noted. 3. Systems in Place: • Staff inserviced on Abuse Policy of investigation and reporting of all allegations of abusde, and how it relates to a Chronically Mentally Ill residents' behavioral plan of care. 4. How Monitored: • DON/Designee will audit/monitor all allegations of abuse for appropriate investigation and reporting. • ADM/Designee will review all audits in the QA daily stand-up meeting when/if an allegation occurs for appropriate investigation and reporting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING _____ B. WING _____	C 01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG, LLC THE	1350 N TODD DR SCOTTSBURG, IN 47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 9 the event with the state reporting guidelines. Complete the Resident Abuse Investigation Report or the Misappropriation of Resident Property Investigation Report. 2. Involved staff members will document the findings in the appropriate medical record, including the notifications made to the physician and family members as indicated. 3. Place the Incident Documentation and Investigation Tool on the 24-hour report for follow-up per policy. 4. Initiate an investigation as soon as possible. An investigation of any allegations of abuse, neglect, involuntary seclusion and misappropriation of property will be conducted. All complaints are taken seriously and are to be thoroughly investigated. The purpose of the investigation is to determine the circumstances surrounding the alleged event and the evidence available to make a final determination. The investigation researches the who, what, where, when, how and why of the incident, consisting of at least the following: A review of the completed Incident Documentation and Investigation tool or Misappropriation of Property Investigation Report; An interview with the person (s) reporting the incident; interviews with any witnesses to the incident; an interview with the resident if possible; a review of the resident's medical record;	F 226	• All Abuse Allegations and reports made to ISDH will be reviewed by the Medical Director and Quality Assurance Committee on a quarterly basis. 5. This plan of correction constitutes our credible allegation of complaince with all regulatory requirements. Our date of compliance is February 26, 2011.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING _____ B. WING _____	C 01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG, LLC THE	1350 N TODD DR SCOTTSBURG, IN 47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 10 an interview with staff members having contact with the resident during the period/shift of the alleged incident; interviews with the resident's roommate, family members and visitors; a review of all circumstances surrounding the incident. Obtain written statement of events that occurred, signed and dated by the person giving the statement of personal knowledge and/or observations. Gather as much information as possible to make a final conclusion about the allegations. 5. While the investigation is being conducted, suspected or accused individuals not employed b the facility will be denied unsupervised access to the resident. Visits may only be made in designated areas, supervised by staff after approval by the Administrator/Designee. 6. Employees of this facility suspected or accused of perpetrating the event shall immediately be barred from any further contact with residents of the facility, pending outcome of further investigation, prosecution or disciplinary action against the employee.	F 226		
F 282 SS=D	3.1-28(a) 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility	F 282	F 282 **Services by Qualified Persons/Care Plan** It is the intent of the facility to follow physician orders to give a medication with meals.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING _____ B. WING _____	C 01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG, LLC THE	1350 N TODD DR SCOTTSBURG, IN 47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 11 must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure physician orders to give a medication with meals was followed for 1 of 18 residents observed during the medication pass. (Resident #23) Findings include: On 1/25/11, during the medication pass at 11:20 a.m., LPN #3 was observed to pour the following medication Renagel (to treat chronic kidney disease in patients on dialysis) 800 mg (milligram) i (one) with meals to Resident #23 with a cup of water. Review of the clinical record for Resident #23 on 1/25/11 at 12 p.m., indicated the following: A signed Physician Order ,dated 1/19/11, "Renagel 800 mg i tablet with meal. Must be taken while eating." Lunch in the Main Dining Room was scheduled for 12:20 p.m., per the Meal Time Schedule provided by the facility on 1/23/11 at 2 p.m. On 1/26/11, during the medication pass at 11:35 a.m., LPN #4 was observed to pour the following medication, Renagel 800mg i with meals to Resident #23. LPN #4 gave the medication with a drink of water. Review of the facility Medication Administration and Infection Control Policy on 1/27/11 at 8:30 a.m., included, but was not limited to: Procedure	F 282	1. Actions Taken: • Nurse was educated/in-serviced on following physician's orders to administer medication as ordered, including with meals. • Resident did not complain or exhibit any signs or symptoms of GI distress 2. Others Identified: • 100% audit of residents with medication orders for med to be given with food. No other problems noted. 3. Systems in Place: • Licensed staff in-serviced on following physician's orders in regards to administering medication with meals/food. 4. How Monitored: • DON/Designee to complete random audit on medication administration 1 time per week for 4 weeks then monthly for 3 months. • Audits will be reviewed by Administrator/Designee in morning stand-up QA meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING _____ B. WING _____	C 01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG, LLC THE	1350 N TODD DR SCOTTSBURG, IN 47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 12 #4 -Review the MAR for allergies, side effects and or other pertinent information, that may effect the safe administration of the medication the resident is to receive. 3.1-35(g)(2)	F 282	• All audits will be reviewed with the Medical Director at the Quarterly Quality Assurance Meeting to determine need for continued monitoring. 5. This plan of correction constitutes our credible allegation of complaince with all regulatory requirements. Our date of compliance is February 26, 2011.	
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility;	F 285	F 285 **PASRR Requirements for MI & MR** It is the intent of this facility to ensure all annual Level II screenings are completed in a timely manner; and a Level II recommendation for a Psychiatric Evaluation is completed. 1. Actions Taken: • Level II screening for resident #49 was completed on 1/25/11. Resident #88 was discharged on December 21, 2010. 2. Others Identified: • SSD completed audit of all residents requiring Level II screening to validate it was current and recommendations had been completed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING _____ B. WING _____	C 01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG, LLC THE	1350 N TODD DR SCOTTSBURG, IN 47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 285	Continued From page 13 and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: A. Based on record review and interview, the facility failed to ensure an annual Level II screening [PASRR - pre-admission screening and resident review] was completed in a timely manner for 1 of 1 supplemental residents reviewed for annual Level II assessments in a supplemental sample of 12 residents. (Resident #49) B. Based on record review and interview, the facility failed to ensure a Level II recommendation for a Psychiatric Evaluation was completed for 1 of 6 residents reviewed with a Level II Evaluation in a sample of 17. (Resident #88) Finding includes: A.1. Review of the clinical record for Resident #49 on 1/26/2011 at 2:00 p.m., indicated the resident had diagnoses which included, but were not limited to, Schizophrenia, bipolar, mood disorder, personality disorder, and anxiety.	F 285	3. Systems in Place: • Implemented tracking system for all residents requiring annual Level II screening to validate it remains current and recommendations completed • In-serviced SSD on monthly follow up on tracking screens. 4. How Monitored: • SSD to audit monthly and provide list of residents due for screening and/or recommendatios for services. • Administrator/Designee to review all audits in daily QA stand-up meeting as completed. • SSD to review results of above mentioned audit to Medical Director and Quality Assurance Committee on Quarterly basis. 5. This plan of correction constitutes our credible allegation of complaince with all regulatory requirements. Our date of compliance is February 7, 2011.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING _____ B. WING _____	C 01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG, LLC THE	1350 N TODD DR SCOTTSBURG, IN 47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 285	Continued From page 14 A 9/09/2009 Level II mental illness screening was located on the chart which indicated a yearly resident review was required. No annual review for 2010 could be located. During an interview on 1/26/2011 at 2:20 p.m. with the representative from the mental health agency who conducted the annual Level II assessments, he indicated that he was not sure why the reviews were being done late and that it was either because the facility had not notified the agency of the need or the agency just never got to it in October. During an interview with the Social Worker on 1/26/2011 at 3:40 p.m., she indicated that she had missed a couple of Level IIs that should have been referred to the local mental health agency earlier and that they were late. B. The clinical record for Resident #88 was reviewed on 1/25/11 at 3:45 p.m. The resident diagnoses included, but were not limited to: Bipolar Disorder. The resident was admitted to the facility on 8/11/10. The PASRR Level II was dated 8/9/10. Specialized Services checked included, but was not limited to "Psychiatric Evaluation." Documentation in the record was lacking of a Psychiatric Evaluation. The resident was discharged from the facility on 12/20/10. On 1/26/11 at 8:20 a.m., during an interview with the Social Worker, she indicated she "missed it."	F 285		
F 323 SS=G	3.1-29(a) 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323	F323 **Free of Accident Hazards/Supervision/Devices**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING _____ B. WING _____	C 01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG, LLC THE	1350 N TODD DR SCOTTSBURG, IN 47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 15 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interview, the facility failed to provide adequate supervision for a cognitively impaired resident (Resident #57) who was at risk for falls, had a fall which resulted in a fractured hip for 1 of 2 residents reviewed for falls in a sample of 17. Findings include: The clinical record for Resident #57 was reviewed on 1/24/11 at 9:30 a.m. The resident diagnoses included but were not limited to dementia, coronary artery disease and fractured left hip. During the initial tour on 1/23/11 between 12:30 p.m. and 1:30 p.m., LPN #1 indicated Resident #57 had a recent fracture which was an in-house fall. The resident was observed lying in bed with a mat on the floor next to the bed. Nurses Notes included, but were not limited to: 1/10/11 710 A "Hospice CNA called this nurse to resident room. Bruise noted on bilateral hips. L (Left) hip 1/2 dollar size R (right) hip from iliac crest to buttocks (middle) sic Resident stated he fell in room yesterday - Doesn't remember how he	F 323	It is the intent of this facility to provide adequate supervision to all residents. 1. Actions Taken: • Immediately upon return from hospital an order was obtained and the mat was placed on floor by side of low bed to prevent injury from fall. • Care plan was updated. • Family and Hospice provider were notified. 2. Others Identified: • 100 % audit of all Fall Risk Assessments to ensure appropriate interventions and appropriate supervision was provided for all residents. No other issues were found. 3. Systems in Place: • Staff in-serviced on falls and appropriate interventions or supervision. 4. How Monitored: • DON/Designee to audit all incident reports as they occur to ensure appropriate interventions and supervision are in place.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING _____ B. WING _____	C 01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG, LLC THE	1350 N TODD DR SCOTTSBURG, IN 47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 16 got up or approx time he fell." Documentation lacking for Nurses Notes on 1/09/11. 1/10/11 7:55 a.m. "N.O.N. (New Order Nursing) Xray bilateral hips, L shoulder. Head C.T. (Computerized Tomography) Send to [named hospital] for CT et (and) xrays. Resident stated he fell yesterday...." 1/10/11 0710 "this nurse and nurse [LPN 1] had not made rounds before hospice nurse came to office. Getting report et (and) counting narcs (medications)." 1/10/11 1115 "Dr. from [named hospital] X-ray dept called et reported resident has fx (fracture) of L hip. Displaced fx of femoral neck of L hip." 1/10/11 12 30 "Xray called again. [Named hospital] to send him back so we could give pain med." 1/10/11 1255 "Return from [named hospital] xray dept per EMS (Emergency Medical System) stretcher..." 1/10/11 215 P "Hospice Chaplain here. Found resident on floor. Head to toe exam no new injury noted. " Documentation was lacking if the left leg was immobilized prior to transferring back to bed. 1/10/11 230 P Bed alarm in place now et working." Documentation was lacking of any interventions being in place once the resident returned to the facility with an unrepaired fractured hip. The Falls (interdisciplinary Care Plan) dated 9/9/10 Problem: resident at risk for falls R/T	F 323	• Audits will be reviewed by Administrator/Designee in morning stand-up QA meeting as completed. • DON to report summary of falls to Medical Director and Quality Assurance Team during Quarterly Quality Assurance Meeting. 5. This plan of correction constitutes our credible allegation of complaince with all regulatory requirements. Our date of compliance is February 26, 2011.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING _____ B. WING _____	C 01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG, LLC THE	1350 N TODD DR SCOTTSBURG, IN 47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 17 (related to) DX (diagnosis) Parkinson, unsteady gait, narcotic med use and hypertension med use and recent fall; Approach: 6/26/10 Bed alarm to alert staff of attempts to transfer unassisted (Res. able to turn off alarm) 1/10/11 Floor mat by bed @ all x's (times) and low bed." In interview with the Director of Nursing on 1/24/11 at 2:45 p.m., she indicated the bed alarm was not effective. "We've even hidden it." An Investigation report related to the incident, dated 1/10/11, was provided by the Director of Nursing on 1/24/11 at 2:50 p.m. "Spoke with CNA #1 who worked Sunday night. She said she witnessed no fall or injury on the resident Sunday night. She did state that resident cont. to turn off alarm and transfer self unassisted. Mat by bed." "Spoke with LPN #2, who worked all weekend. She witnessed no falls or injuries on resident. Res. unplugs alarm. Alarm maneuvered behind bed. Res. does cont. to find and remove."	F 323		
F 371 SS=F	3.1-45(a)(2) 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F 371 **Food Procure, Store/Prepare/Serve-Sanitary** It is the intent of this facility to maintain equipment in good repair and cleaned after each use. It is also the intent of this facility utilize proper handwashing techniques and infection contral procedures.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING _____ B. WING _____	C 01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG, LLC THE	1350 N TODD DR SCOTTSBURG, IN 47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure equipment was clean, in good repair, and hands were washed for 2 of 2 dietary observations. This deficient practice had the potential to affect 82 residents receiving meals from the kitchen. Findings include: Observation of the kitchen on 01/23/11 between 1:34 p.m. and 2:00 p.m. the following was noted: 1. The can opener blade was soiled with a dried brownish red substance. 2. Ten steam table pans stacked together and stored as clean were wet or soiled with food debris on the inner surfaces. Observation on 01/25/11 between the hours of 3:50 p.m. and 6:45 p.m., the following was noted: 3. Dietary Aide #1 was pureeing pineapple, lifted the trash lid, did not wash his hands nor replace his gloves. He returned to pureeing the fruit. In interview, at this time, he indicated he was new and did not know to wash hands after touching the trash lid. 4. Three steam table pans stacked together and stored as clean were soiled with dried food debris or wet on the inner surfaces. 5. Six large spatulas stored as clean and ready for use were torn on the edges with pieces loose.	F 371	1. Actions Taken: • The can opener blade was cleaned • The steam table pans were washed and air dried • Dietary Aide #1 was educated/in-serviced on proper handwashing techniques, glove usage and infection control procedures • Spatulas were replaced with new ones • The soup/cereal bowls were washed and air dried 2. Others Identified: • Registered Dietician completed sanitation inspection of the kitchen including handwashing, glove usage and general infection control procedures. 3. Systems in Place: • Staff has been in-serviced regarding proper infection control procedures, handwashing and maintaining equipment in good repair and kitchen sanitation. • Bowls, pots and pans will be left in tray to dry to ensure they are not put away wet.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING _____ B. WING _____	C 01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG, LLC THE	1350 N TODD DR SCOTTSBURG, IN 47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 19 6. Ten cereal/soup bowls stored as clean were soiled with food debris and wet on the inner surfaces. 7. Dietary Aide #1, picked plastic bags off the floor, and failed to wash his hands. 8. Dietary Aide #1 left the prep line, entered the walk- in and returned to the prep line after touching the door handle of the walk- in utilizing the same gloves. 3.1-21(i)(3)	F 371	4. How Monitored: • CDM/Designee will complete an audit of pots, pans and bowls daily, 5 days a week for 8 weeks. • CDM/Designee will complete an audit daily, 5 days a week for 8 weeks to validate proper handwashing techniques/infection control procedures are being utilized.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced	F 425	• Audits will be reviewed by Administrator or Designee in morning interdisciplinary team meeting • Results of all audits will be reviewed with Medical Director at Quarterly Quality Assurance Meeting. 5. This Plan of Correction constitutes our credible allegation of compliance with regulatory requirements. Our date of compliance is February 26, 2011. F 425 **Pharmaceutical/Accurate Procedures**	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING _____ B. WING _____	C 01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG, LLC THE	1350 N TODD DR SCOTTSBURG, IN 47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 20 by: Based on observation and interview, the facility failed to ensure medications were destroyed or returned for credit in accordance with accepted standards and state rules for 1 of 17 sampled residents and 2 of 12 residents in a supplemental sample of 12, whose medications had been discontinued or expired. (Resident #32, 35, 43) Findings include: On 1/25/11 at 11:46 a.m., with the Director of Nursing present, the following was observed in the medication room: 1. Resident #32 had Amrix (skeletal muscle relaxant) 15 mg (milligram) 25 capsules on hand. The medication had been discontinued on 1/6/11. 2. Resident #35 had Potassium (electrolyte replacement) 10 meq (milliequivalents) 68 capsules on hand. The medication had been discontinued on 12/4/10. 3. Resident #43 had 23 Tylenol (anti-inflammatory) 500 mg tablets on hand. The medication expired on 12/15/10. On 1/25/11 at 11:46 a.m., in interview with the Director of Nursing, at this time, she indicated "the medication needed to be returned or destroyed within seven days." 3.1-25(o) 3.1-25(r)	F 425	It is the intent of this facility to return for credit and/or destroy medication in accordance with accepted standards and state rules. 1. Actions Taken: • In regards to residents # 32, #35, and #43; all medications were returned for credit and/or destroyed per facility policy. 2. Others Identified: • All Medication Rooms were inspected. No other issues noted. 3. Systems in Place: • Nursing staff in-serviced on facility protocol for returning medication for credit and destruction of medications. 4. How Monitored: • DON/Desginee to inspect/audit Medication Rooms 3 times a week to validate compliance with policy.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING _____ B. WING _____	C 01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG, LLC THE	1350 N TODD DR SCOTTSBURG, IN 47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 21 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441	• Audits will be reviewed by Administrator/Designee in morning interdisciplinary team meeting • Results of all audits will be reviewed with Medical Director at Quarterly Quality Assurance Meeting to determine if further monitoring is required. 5. This plan of correction constitutes our credible allegation of complaince with all regulatory requirements. Our date of compliance is February 26, 2011. F 441 **Infection Control, Prevent Spread, Linens** It is the intent of this facility to maintain proper infection control procedures during medication administration. 1. Actions Taken: • Nurses were educated/in-serviced on medication administration and appropriate infection control techniques to be observed..	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING _____ B. WING _____	C 01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG, LLC THE	1350 N TODD DR SCOTTSBURG, IN 47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 22 Based on observation, interview and record review, the facility failed to ensure the facility policy for infection control was followed by 2 of 8 nurses observed passing medications. (Licensed Practical Nurse (LPN) #3 and LPN#4) This affected 8 of 18 residents during observation of medication pass. (Residents #19, 23, 28, 31, 32, 35, 39 and 40) Findings include: 1. During the medication pass observation on 1/25/11 at 11:20 a.m., LPN#3 punched medication from a punch card for Resident #23. The medication dropped on to the top of the medication cart. The LPN picked up the medication with her bare hand, placed it in a medication cup and administered the medication to the resident. 2. On 01/26/11, during the noon medication pass, Licensed Practical Nurse #4, was observed to pass medications to seven residents in a supplemental sample of 11 and 1 of 1 residents in a sample of 17. (Residents 19, 23, 28, 31, 32, 35, 39, and 40) The LPN removed medications from the punch cards into her bare hand for all of the above residents. She was observed to occasionally wash her hands, but continued to touch the keys to open the cart, touched the cart drawers prior to punching medications into her bare hands. Review of the policy for "Oral and Sublingual medications provided by the facility on 1/27/11 at 8:30 a.m., the following under Procedure:.#7 was noted. "#7. Pour the correct number of tablets or	F 441	• LPN #3 provided documentation that the medication dropped on medication cart was not given but was actually wasted, per protocol and the wasted pill was observed by ADON to be in the sharps container. 2. Others Identified: • DON/Designee conducted random observations of all nurses during medication administration. No other issues noted. 3. Systems in Place: • Nursing staff in-serviced on proper infection control and medication administration techniques 4. How Monitored: • DON/Designee to complete observation/audit of medication administration 1 time a week on a nurse chosen at random for 8 weeks and monthly thereafter for 6 months.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING _____ B. WING _____	C 01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG, LLC THE	1350 N TODD DR SCOTTSBURG, IN 47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 23 capsules into the medication cup without touching the medications." In interview with the Director of Nursing on 1/26/11 at 4 p.m., she indicated "Nursing was not to pick medication up with ungloved hands." 3.1-18(b) 3.1-18(l)	F 441	• Administrator/Designee will review all audits as completed to ensure completion. • Observations will be reviewed with Medical Director at quarterly Quality Assurance Meeting to determine if continued monitoring is required.. 5. This plan of correction constitutes our credible allegation of complaince with all regulatory requirements. Our date of compliance is February 26, 2011.	